To: Dr. Kara Odom Walker, Secretary, Department of Health and Social Services

From: Delaware Healthcare Association

Date: November 13, 2017

**Re: Updated Statement of Guiding Principles for Payment Reform and Benchmark Proposal Discussions**

Overview:

The Board of Directors of the Delaware Healthcare Association (DHA) submits this Statement of Guiding Principles ("Statement") in response to the request for stakeholder comment on the draft "Delaware's Road to Value" document, and for consideration as part of the ongoing dialogue around the Department of Health and Social Services' health care cost benchmark proposal.[1]

The Delaware Healthcare Association continues to support acceleration of delivery and payment reform models focused on delivering value and we look forward to continuing the dialogue with State policy leaders and other stakeholders about how to expedite the State's migration towards value-based payment models. We strongly supported and participated in the substantial stakeholder-driven work of Delaware's State Innovation Model ("SIM") initiative. The SIM work advanced our State's health care delivery system in developing new delivery and payment models focused on moving toward value-based care, improving care coordination for chronic disease, reducing variations in care, and accelerating structures such as Accountable Care Organizations to support risk-based payment models. We are concerned that the current DHSS approach is limited to a focus on costs only, without sufficient attention - or an ongoing commitment - to other components of true healthcare transformation that are underway.

The current DHSS plan lacks sufficient detail on the creation, composition, operation or governance of a benchmark in Delaware to enable true evaluation of the benefits and detriments of such an initiative for the communities cared for by our member hospitals. We are quite concerned about the breadth and oversight authority of the state bureaucracy needed to oversee a benchmark, including the quite real potential

[1] Delaware Department of Health and Social Services (DHSS), *Draft, Delaware's Road to Value*, October 2017, http://dhss.delaware.gov/dhcc/.

for government overreach. We posit that DHSS should consider an initial focus on our state's most vulnerable populations, including those with substance use disorder as a result of the opioid epidemic and children with complex needs, among other potential issues. Such a focus would help address the needs of the populations most impacting the state budget and advance new payment models for those populations to improve health outcomes and drive value.

As we move forward and consider DHSS's health care cost benchmark proposal, it is imperative that any proposed structure focus first on the healthcare needs of the patients and families our member hospitals serve. In particular, it is imperative that efforts to reduce the health care cost trend not assign undue hardships on society's sickest and most vulnerable citizens. We believe these shared goals are achievable, but this process cannot compromise the ability of Delaware's health care providers, including DHA member hospitals and health systems, to continue to provide comprehensive and high quality care for our community.

**Delaware Healthcare Association Statement of Guiding Principles for Payment Reform and Benchmark Proposal Discussions**

The Guiding Principles outlined in this Statement are grouped into the following categories: (1) Benchmark Development Process and Communications; (2) Benchmark Scope; (3) Governance and Data; and (4) Other Concerns.

## I. Benchmark Development Process and Communications

**a.** While we appreciated the opportunity to attend the series of benchmark summits and learn about approaches that have worked in select states, these summits should not be a substitute for true stakeholder engagement and a collaborative consideration of approaches that will work in Delaware. Delaware's plan should be based specifically on Delaware's data and Delaware's opportunities, and leverage the deep healthcare knowledge and expertise that exist within the State.

**b.** Such stakeholder engagement should include a collaborative and transparent process to craft any proposals, including an ongoing iterative dialogue through which the State can obtain input during the development of specific legislative, regulatory or other policy proposals as well as obtain feedback on draft proposals. Such proposals should include far more detail than what is outlined in this roadmap or similar documents. Stakeholder engagement is particularly important with regard to the operational considerations necessary for the successful implementation of the benchmark.

**c.** The State and its consultants should provide information and proposals to DHA and other stakeholders with enough time to allow for thoughtful and thorough response as well as iterative discussion where needed.

## II. Benchmark Scope

**a.** The creation of a benchmark should be one that is fair, transparent, flexible, and allows for adjustments in response to ongoing changes in demographics, health status and policy decisions.

**b.** The benchmark should also: 1) recognize the environmental and social factors that impact the health of Delawareans; 2) include all health care costs, beyond clinical prevention, management and acute care; and 3) account for the State's investment in addressing these social determinants of health.

**c.** The benchmark process should make recommendations for a comprehensive State approach to improving the social and environmental conditions that negatively impact the health of Delawareans.

**d.** The State's benchmark process should build on the considerable time, effort and funding that the State, hospitals and other providers and stakeholders have already invested in the SIM work. Many of the ideas reflected in the "Delaware's Road to Value" white paper appear to be taken nearly verbatim from the State's SIM application and other

documents, and there needs to be a more explicit recognition of the community-wide work upon which this benchmark is building.

**e.** DHA strongly supports the stated intent of the Secretary that any benchmark and Total Cost of Care measurements are rendered and applied on a per capita basis.

**f.** The benchmark should truly reflect necessary Total Cost of Care within the state given the population served as well as appropriate risk sharing by providers. The benchmark should not be utilized as an adjustable response to State budget challenges or as a tool to ration necessary health care services for the population, especially in light of the demographics of Delaware and the needs of our aging population and those with special health care needs. Legitimate concern about the cost curve should be viewed in the context of how "per capita" calculations can play out in a small state.

**g.** Any benchmark should be based upon a measure that is relevant and health care related, reflecting the current health care needs of Delaware's population and not simply the national trend, especially a trend that may be dated. The State should carefully consider the various alternatives as relevant measures. A benchmark tied to projected revenue growth in Delaware does not make sense the same way it may apply in other states, given the state's current structural deficiencies resulting from Delaware's unique reliance upon non-traditional sources of revenue, including escheat collections and corporate franchise fees.

**h.** A benchmark should not be negative, which could happen in a recession year if a benchmark is tied to state revenues.

**i.** Any benchmark should be risk adjusted to accommodate Delaware's population demographics and health status (i.e., aged; obese, high prevalence of diabetes, high tobacco use, ongoing opioid epidemic, high infant mortality rate, high prevalence of maternal risks, etc.).

**j.** Any benchmark should require base adjustment to reflect policy changes (new coverage mandates), unforeseen input changes (an expensive wonder treatment or drug like that addressing Hepatitis C, or CAR-T therapy, for example) or surges resulting from natural or man-made disasters, public health crises, etc.

**k.** Flexibility should include recognition and acknowledgement of potential impacts on the benchmark that are due to pilots, innovative approaches to population health improvement, or other initiatives focused on learning and improving the health care delivery system.

**l.** The benchmark should consider and factor in the different services and acuity managed by each hospital, health system or provider (including academic programs as well as services such as trauma care, comprehensive stroke care, neonatal intensive care units, etc.). The benchmark should also be limited to Delaware residents and not include patients from other states and countries who seek care at our facilities, often for specialized or higher level services than are available in their communities.

**m.** All providers, insurers and other relevant contributors to health care costs should be subject to the benchmark, including pharmaceutical, medical device, home health, post-acute/skilled nursing, among others.

**n.** Infrastructure costs should not be included in Total Cost of Care.

## III. Benchmark Governance and Data (including data sources and data governance)

**a.** Any benchmark should not require significant additional resources (i.e., infrastructure costs) on the part of the State or providers that are not offset by clearly defined and identified savings to the health care system.

**b.** The process to develop and manage a benchmark should be data driven using reliable, current and accurate health outcomes, quality, and cost trend data agreed to by the state and providers. This data should be used to identify opportunities to improve the health care delivery system and lower the cost trend.

**c.** Data should be reviewed by an independent health care economist or other subject matter expert during the development of the benchmark and on an ongoing basis (at least quarterly) and such reviews should be done in a transparent manner with the opportunity for comment.

**d.** Open access to and transparency for all data utilized in planning for payment reform and benchmark design must be the standard.

**e.** Cost trend data used to inform any benchmark must be comprehensive and should include all major sources of health care spending, including pharmaceutical costs and third party administrative costs, including potentially redundant administrative costs and insurer costs.

**f.** The Delaware Health Information Network (DHIN) already has in place the governance structure and statutory authority for a payer claims database, and has a proven track record of administering one of the leading Health Information Exchanges in the U.S. The State, DHA and many other stakeholders have already invested considerable time and effort in developing and maintaining the DHIN, and DHA will not support a benchmark initiative that requires the creation of a new, and separate, claims data repository.

g. The authority of any governance body created in the context of the benchmarking process should be limited to establishing, monitoring and overseeing compliance with the benchmark, and should not serve as a regulatory body with jurisdiction and oversight over operational elements of the health care system.

**h.** A governance body for payment reform and benchmarking should be participatory and include representation from Delaware's hospitals and health systems to ensure the buy-in and accountability necessary to succeed.

**i.** A variety of governance structures currently exist that could serve as a model, including the Delaware Health Care Commission, the Delaware Center for Health Innovation, and DEFAC, among others.

**j.** Where appropriate, the benchmark process may present an opportunity to consolidate governance for some existing bodies without losing the authority or contributions of each individual group.

**k.** In considering a new governance structure for the benchmark, and consistent with the stated desire to identify all potential sources of health care system cost savings, the State should conduct a thorough review (with stakeholder input) into existing State Medicaid regulations and Provider Manuals, and should consider consolidating, modernizing and eliminating redundant regulations that impose unnecessary costs and administrative burden into the system.

**l.** The algorithm for any benchmark should be stated in Code, subject to regulatory action and updates, and allow for flexibility for unforeseen occurrences as discussed above.

## IV. Other Issues

a. The governance approach for reviewing providers that exceed the benchmark should seek understanding, learning and be fair and meaningful regarding responsive action.

b. As part of the benchmark process and a coordinated state health policy approach, the State of Delaware and other public entities must drive appropriate and meaningful change over the costs they control, including:

   i. Benchmarks for state employee benefit plan design;
   ii. Utilization of pharmaceutical pricing strategies and other decisions that can be made to moderate total costs of care (for example, the use of 340B drug pricing in the Medicaid program);
   iii. Adopting cost sharing models for state employees that incentivize healthy behaviors and can lead to improved health outcomes; and
   iv. Exploring new approaches to traditional government healthcare programs that may produce shared savings between the public and private sectors.